No. 95-1594

Supreme Court, U.S.
FILED
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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

—against—

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED APRIL 3, 1996
CERTIORARI GRANTED OCTOBER 15, 1996

105 pp

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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4/16/92	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $120.00 RECEIPT # 166349 (1a) [Entry date 04/22/92]
6/9/92	10	Rule 3(g) statement filed by David Axelrod, Lorna H. McBarnette, Steven C. Anderman (jh) [Entry date 06/10/92]
6/9/92	11	ANSWER to Complaint by David Axelrod, Lorna H. McBarnette, Steven C. Anderman (Attorney Richard Corenthal); Firm of: Robert Abrams by attorney Richard Corenthal for defendant David Axelrod (jh) [Entry date 06/10/92]
7/31/92	12	MEMORANDUM by David Axelrod, Lorna H. McBarnette, Steven C. Anderman in support of Defendants' Motion for Summary Judgment (sc) [Entry date 08/03/92]
7/31/92	13	AFFIDAVIT in support of Richard Corenthal by David Axelrod, Lorna H. McBarnette, Steven C. Anderman Re: Defendants' Motion for Summary Judgment (sc) [Entry date 08/03/92]
7/31/92	14	AFFIDAVIT of Richard Pellegrini by David Axelrod, Lorna H. McBarnette, Steven C. Anderman Re: (sc) [Entry date 08/03/92]
9/24/92	16	NOTICE OF MOTION by NYSA-ILA Medical and for summary judgment, Return date (jh)

9/24/92	17	MEMORANDUM by NYSA-ILA Medical and in support of [16-1] motion for summary judgment (jh)
10/21/92	19	MEMORANDUM by David Axelrod, Lorna H. McBarnette, Steven C. Anderman in opposition to [16-1] motion for summary judgment (jh) [Entry date 10/22/92]
11/4/92	20	REPLY MEMORANDUM of law by NYSA-ILA Medical and (jh)
2/23/93	21	MEMORANDUM OPINION # 71096 denying [16-1] motion for summary judgment (Signed by Judge John S. Martin); Copies mailed. (jh) [Entry date 02/25/93]
3/1/93	22	JUDGMENT # for Lorna H. McBarnette, Steven C. Anderman, David Axelrod against NYSA-ILA Medical and Clinical Services Fund The complt is dismissed etc (James M. Parkison, Clerk); Mailed copies and notice of right to appeal. (jh) [Entry date 03/02/93]
3/1/93	—	Case closed (jh) [Entry date 03/02/93]
3/16/93	23	NOTICE OF APPEAL by NYSA-ILA Medical and; from [22-1] judgment order. Copies of notice of appeal mailed to Attorney(s) of Record: Richard Corenthal, Jane Baker and Robert Abrams. (jf)
4/29/93	26	MANDATE OF USCA (certified copy) Re: the appeal shall be deemed withdrawn with prejudice (jh) [Entry date 07/08/93]
11/1/93	29	True Copy of Order from the USCA as to Lorna H. McBarnette, Steven C. Anderman, David Axelrod RE: [0-0] transmitted appeal reinstate the appeal in the above matter (jh) [Entry date 01/24/94]

11/1/93	—	Appeal reinstated by NYSA-ILA Medical and [23-1] appeal by NYSA-ILA Medical and USCA NUMBER: 93-7221 (jh) [Entry date 01/24/94]
7/19/94	30	MANDATE OF USCA (certified copy) Re: [0-1] appeal by NYSA-ILA Medical, etc.: It is hereby ordered, adjudged and decreed that the judgment of the district court be and it hereby is reversed in accordance with the opinion of this court. Bill of costs in favor of appellants NYSA-ILA Med. Clinical Svces. Fund etc., in the amount of $1,366.40 attached. GEORGE LANGE III, Clerk, U.S.C.A. (em)
5/4/95	33	ORDER, adjourning pretrial conference sine die, and counsel for the plaintiff shall inform the Court at such time as the Second Circuit renders a decision in this matter (signed by Judge Denise L. Cote); Copies mailed (jr) [Entry date 05/10/95]
2/7/96	35	MANDATE OF USCA (certified copy) Re: On consideration whereof, it is now hereby ordered, adjudged and decreed that the judgment of the district court be and it hereby is reversed and remanded to the district court for further proceedings in accordance with the opinion of this court. (93-7221). GEORGE LANGE III, Clerk, U.S.C.A. (em)
2/7/96	36	Bill of costs in favor of the Appellant, NYSA-ILA Medical & Clinical Svces. Fund in the amount of $246.82. (93-7221). GEORGE LANGE III, Clerk, U.S.C.A. (em)

2/7/96 — DOCKETED AS A JUDGMENT # 96,0253 ON 2/8/96. ENDORSED ON DOC# 36 (kk) [Entry date 02/08/96]

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D.C. 20543

October 15, 1996

Ms. M. Patricia Smith
Assistant Attorney General
120 Broadway
New York, NY 10271

Re: Barbara A. De Buono, New York Commissioner of Health, et al.
v. NYSA-ILA Medical and Clinical Services Fund, etc., et al.
No. 95-1594

Dear Ms. Smith:

The Court today entered the following order in the above entitled case:

The petition for a writ of certiorari is granted.

Sincerely,

/s/ WILLIAM K. SUTER
William K. Suter, Clerk

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

On remand from Supreme Court

(Submitted November 15, 1995 Decided January 4, 1996)
Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Plaintiffs-Appellants,

—v.—

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Defendants-Appellees.

Before:

WALKER and JACOBS, *Circuit Judges*,
and ZAMPANO, *District Judge*.*

PER CURIAM:

On June 23, 1994, we entered a judgment and filed an opinion, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823, which reversed a summary judgment entered February 23, 1993 by the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*). The district court had held that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, did not preempt New York's Health Facility Assessment ("HFA"), N.Y. Pub. Health Law § 2807-d, reasoning that the tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan." In reversing, we held that the HFA directly affected and was therefore "related to" the Fund in its principal role as an employee welfare plan.

On May 1, 1995, the Supreme Court entered an order granting certiorari, vacating the judgment of this court, and remanding the case to us for further consideration in light of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), *rev'g* 14 F.3d 708 (2d Cir. 1994). *See Chassin v. NYSA-ILA Medical & Clinical Servs. Fund*, 115 S. Ct. 1819 (1995).

We ordered counsel for the parties to brief the issue of whether *Travelers* requires a different result in this case.

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* Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

Upon receipt of these briefs, we carefully reconsidered this case in light of *Travelers*. For the reasons that follow, we adhere to our original decision reversing the judgment of the district court.

The undisputed facts in this case have been set forth both in the district court opinion and in our original opinion, and we therefore do not fully restate them here. The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that ERISA preempts New York Public Health Law § 2807-d to the extent that the HFA taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. On appeal, we found that the HFA directly "relates to" the Fund in that "[t]he tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received." *Axelrod*, 27 F.3d at 827.

Upon reconsideration in light of the Supreme Court's holding in *Travelers*, we conclude that the ground upon which our earlier decision in this case rested remains undisturbed. *Travelers* involved a challenge to New York's imposition of a surcharge on hospital bills paid by commercial insurers and Health Maintenance Organizations but not on hospital bills paid by Blue Cross/Blue Shield insurers. The statute at issue in *Travelers* did not impose surcharges on ERISA plans themselves, but on insurance carriers providing health insurance coverage to the plans and their beneficiaries. The surcharge consequently raised costs to the patient, who remained liable for the balance of any bill an ERISA plan or insurance carrier refuses to pay. The Supreme Court concluded that "a law operating as an indirect source of merely economic influence on administrative decisions [by ERISA plans], as here, should not suffice to trigger pre-emption." *Travelers*, 115 S. Ct. at 1680.

The facts of the present case distinguish it from *Travelers*, because, unlike in *Travelers*, there is no third party between the plan and the tax imposed pursuant to the HFA. Rather, the statute at issue depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan. As we observed in our original opinion, the HFA imposes "an immediate tax on payments and contributions which were intended to pay for participants' medical benefits . . . [and] thus directly affects the Fund in its principal role as an employee welfare benefit plan." *Axelrod*, 27 F.3d at 827.

Nothing in *Travelers* undermines our reliance on the HFA's direct economic impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption. Because our reasoning is not inconsistent with the Supreme Court's opinion in *Travelers*, we adhere to our original disposition that reversed and remanded this case.

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

(Argued March 10, 1994 Decided June 23, 1994)

Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, By Its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Plaintiffs-Appellants,

—v.—

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Defendants-Appellees.

Before:

WALKER and JACOBS, *Circuit Judges*, and ZAMPANO, *District Judge*.*

WALKER, *Circuit Judge*:

The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts New York Public Health Law § 2807-d to the extent the latter provision taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. The Fund now appeals from a judgment of the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*) holding that ERISA does not preempt the state tax and granting summary judgment to defendant state health care officials. We reverse.

BACKGROUND

The Fund is an ERISA-regulated multiemployer, labor-management trust fund established through collective bargaining to administer an employee welfare benefit plan that provides medical, dental, and other health care services to ERISA plan participants, consisting primarily of longshore workers, and their dependents. The Fund provides these health care benefits through three medical centers that it owns and operates, two in

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* Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

New York and one in New Jersey. The centers provide treatment exclusively to plan participants and beneficiaries.

In 1990, the State of New York enacted a Health Facility Assessment ("HFA"), which imposed a tax on the gross receipts from patient care services and general operations of all hospitals in New York State. N.Y. Pub. Health Law § 2807-d. The HFA was enacted to help eliminate the State's budget deficit for the 1990-91 fiscal year. The HFA became effective January 1, 1991, and was supposed to expire on April 1, 1992, but has subsequently been amended to remain in force on and after that date. 1992 N.Y. Laws, ch. 41, §§ 54, 163. The HFA applies to a wide range of medical facilities, including diagnostic and treatment centers such as the medical centers operated by the Fund. N.Y. Pub. Health Law § 2801(1). The amount of the assessment, which varies by type of facility, is six-tenths of one percent for the Fund's medical centers. *Id.* § 2807-d(2)(c). For purposes of the assessment, "gross receipts" are defined as "all monies received for or on account of hospital and health related services" with only limited exceptions. *Id.* § 2807-d(3)(c).

The Fund's medical centers receive income from a variety of sources. The bulk of their costs are covered by employer contributions remitted to the Fund which are then transferred to the centers on an as-needed basis to pay for the centers' payroll and other operating expenses. However, the centers obtain additional revenue from certain employer payments made directly to the centers, employee co-payments, other fee-for-service payments, patient registration fees, payments from workers' compensation carriers, and such miscellaneous sources as the sale of scrap or waste, fees for reproducing medical records, and supplier rebates. For the period from January 1, 1991 to November 30, 1991, the Fund's two New York medical centers reported combined assessable income of $1,177,670 and paid assessments totalling $7,066. The Fund discontinued filing HFA reports with the New York State

Department of Health after November 1991 and has paid no assessments since that time.

The medical centers did not include in their assessable income monies transferred from the Fund to the centers, and the State defendants have not contested the exclusion of these payments in this case. However, the question of whether monies transferred from the Fund to the centers are assessable has never, to our knowledge, been litigated or definitively resolved. Since early 1992, the Fund has restructured its payment procedures so that certain employer contributions and registration fees that were formerly paid directly to the medical centers are now remitted to the Fund itself. The Fund believes that this restructuring avoids the effect of the HFA, but is unwilling to redirect to the Fund all payments now received by the medical centers until this case has been decided.

The Fund instituted this suit in April 1992 asserting that ERISA preempts the HFA insofar as it imposes a levy on contributions and payments for health care benefits provided by the Fund. The Fund does not challenge imposition of the HFA on the centers' miscellaneous revenue earned from activities unrelated to the health care services provided to participants and beneficiaries, such as the income derived from the sale of scrap, records reproduction fees, and supplier rebates. The Fund sought declaratory and injunctive relief as well as restitution of a substantial portion of the HFA assessments it had previously paid.

On cross-motions for summary judgment, the district court ruled that the HFA is a tax of general application that is not preempted by ERISA because it has only an incidental impact on ERISA plans. The district court reasoned that the minimal tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan which might trigger preemption." *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 92 Civ. 2279 (JSM), slip op. at 8 (S.D.N.Y. Feb. 18, 1992). Accordingly, the district court entered judgment dismissing the action and this appeal ensued. We review the district court's

decision *de novo*. *See Westinghouse Elec. Corp. v. New York City Transit Auth.*, 14 F.3d 818, 821 (2d Cir. 1994).

DISCUSSION

ERISA was enacted in 1974 "to promote the interests of employees and their beneficiaries in employee benefit plans," including both pension and welfare plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). An "employee welfare benefit plan" is defined in the statute as

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

29 U.S.C. § 1002(1). The parties do not dispute that the Fund qualifies as an employee welfare benefit plan that fulfills its institutional mission by providing medical benefits directly to plan participants and their beneficiaries through Fund-operated medical centers.

One of ERISA's main objectives was to eliminate state regulation of employee benefit plans. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Shaw*, 463 U.S. at 99 (quoting legislative history). To accomplish this, Congress enacted an express preemption clause that is "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). It provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the law. 29 U.S.C. § 1144(a). The Supreme Court has observed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."

Shaw, 463 U.S. at 96-97. Preemption thus applies even where a state law was not specifically designed to regulate the terms and conditions of employee benefits plans or does not relate to those subjects covered by ERISA, such as reporting, disclosure, and fiduciary responsibilities. *See Ingersoll-Rand Co.*, 498 U.S. at 137-39; *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Shaw*, 463 U.S. at 98. Indeed, even where a state law has no express link to an employee benefit plan, it can be preempted " 'insofar as' the law applies to benefit plans in particular cases." *Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 49 (1992) (quoting *Shaw*, 463 U.S. at 97 n.17).

ERISA preemption is not without limitations, however. The Supreme Court has recognized that ERISA preemption will not apply to state laws that "affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. When it announced this limitation, the Court "express[ed] no views about where it would be appropriate to draw the line," *id.*, but it has subsequently observed that this limitation will apply "with many laws of general applicability," *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 n.1 (1992). There are a number of cases that bear out this observation. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (state law requiring one-time severance payment not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (state escheat law not preempted when applied to recover unclaimed ERISA plan benefits), *cert. denied*, 493 U.S. 811 (1989); *see also Matter of Dyke*, 943 F.2d 1435, 1447 (5th Cir. 1991) (collecting cases). Unfortunately, these decisions have provided no sure method for determining whether the HFA's impact on the Fund is too "tenuous, remote, or peripheral" to trigger ERISA preemption.

The State argues that the HFA is a state tax law of general application that affects ERISA plans only incidentally.

According to the State, the HFA is no more directed at ERISA plans than laws implementing sales taxes, utility taxes, and gasoline taxes, and should thus be seen simply as a "cost of doing business" within the state. Relying on *Mackey* and *Aetna Life Ins. Co.*, the State contends that the HFA should not be preempted because it covers ERISA plans only by virtue of the plans' inclusion in a broader class of entities subject to regulation.

However, we believe that the HFA is distinguishable from these laws of general application. The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in, such as purchasing gasoline or paying one's employees. Rather, the HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them. In a case such as the present one where the plan has chosen to provide medical benefits through self-run medical centers, the HFA operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits. The HFA thus directly affects the Fund in its principal role as an employee welfare benefit plan. It does not touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries.

We thus conclude that the HFA "relates to" the Fund and does so in a very direct way. The tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received. Both impacts will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote or tenuous. *See Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 720 (2d Cir. 1993) ("[T]he surcharges here force ERISA

plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA."), *petition for cert. filed*, 62 U.S.L.W. 3625 (U.S. Mar. 9, 1994) (No. 93-1414); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.) ("The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation."), *cert. denied*, 112 S. Ct. 585 (1991).

Our decision would remain the same even if we assumed that the Fund could avoid the HFA by restructuring its finances so that funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers. Wholly apart from whether the transmission of assets from the Fund to the centers could be taxed without running afoul of ERISA preemption, an issue we need not and do not decide, such a restructuring would alter the Fund's established method of administration and would require it to implement procedures for its New York facilities that differ from those of its New Jersey facility. Moreover, these changes would not be insignificant since they would affect the Fund's primary means of collecting contributions and paying for benefits. A state law that "relates to" an ERISA plan is not saved from ERISA preemption by the fact that a plan could restructure its operations to avoid the impact of the state law. Requirements under state law that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis are features of state regulation that ERISA was designed to prevent. *See FMC Corp.*, 498 U.S. at 59-60; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 918 (D. Conn. 1978) (Newman, J.). *Compare Aetna Life Ins. Co.*, 869 F.2d at 147 (discounting Fund's complaint that it would need to make administrative and accounting adjustments in order to comply with state escheat law because the impact was not substantial enough).

The district court acknowledged that the HFA will directly impact the Fund by leaving less money for benefits, but determined that the magnitude of the impact was too insubstantial to trigger preemption since the tax rate was only .6%. We do no agree with this reasoning. The magnitude of a statute's economic impact on employee benefit plans may enter the analysis where the statute's connection to the ERISA plan is otherwise insufficient for preemption. For example, a real estate gains tax that has only a peripheral connection to ERISA plans may still be subject to preemption if the high rate of tax has a substantial economic impact on a plan. *See Morgan Guar. Trust Co.*, 80 N.Y.2d at 51-53 (ten percent tax on gain from ERISA plan's sale of real property preempted because of direct impact on plan's administration and investment strategy). However, the converse is not true. A statute that "relates to" ERISA plans cannot escape preemption simply because the magnitude of the impact is thought to be insubstantial. Adopting such an approach would contravene the policy that underlies the preemption provision of protecting ERISA plans from state regulation and would open the door to endless litigation about what constitutes a "substantial" impact.

Travelers Insurance Co. v. Cuomo, *supra*, is not to the contrary. In that case, we held that New York surcharges on hospital rates were preempted by ERISA to the extent ERISA plans must pay surcharges. In the course of our analysis, we discussed Judge Martin's opinion in this case without criticizing it. However, we cited it only for the proposition that "a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." 14 F.3d at 721. We did not endorse—and now expressly refuse to endorse—the converse proposition urged by the State: that a regulation which has a *de minimis* economic impact on ERISA plans may withstand preemption regardless of what plan operations it affects.

For the foregoing reasons, we reverse the judgment of the district court.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Civil Action No.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

COMPLAINT

Plaintiffs, the Trustees of the NYSA-ILA Medical and Clinical Services Fund (hereinafter the "Fund"), by their attorneys, Thomas W. Gleason and Lambos & Giardino, as and for their complaint, respectfully allege as follows:

NATURE OF THE ACTION

1. This action seeks relief:

(A) declaring, pursuant to 28 U.S.C. § 2201, that New York Public Health Law § 2807-d is with respect to the plaintiffs, null, void and ineffective under the Supremacy Clause of Article VI of the Constitution of the United States because such provision is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*;

(B) permanently enjoining the defendants from administering and enforcing New York Public Health Law § 2807-d insofar as it requires the plaintiffs to pay any assessments to defendants; and

(C) granting damages to plaintiffs in the amount of all monies paid to defendants pursuant to New York Public Health Law § 2807-d, together with lawful interest thereon.

JURISDICTION

2. Jurisdiction exists pursuant to ERISA § 502, 29 U.S.C. § 1132, and 28 U.S.C. § 1331 in that the dispute arises under the Constitution and Laws of the United States.

VENUE

3. Venue is proper pursuant to 29 U.S.C. § 1132 in that the Fund is administered in the Southern District of New York.

PARTIES

4. The plaintiffs are the Trustees of the Fund. The Fund is a jointly administered, multiemployer, labor-management trust fund established in accordance with Section 302 of the Labor-Management Relations Act of 1949, 29 U.S.C. § 186, and pursuant to an Agreement and Declaration of Trust and

Plan and collective bargaining agreements between New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA"), prescribing the terms and conditions of longshore employment in the Port of New York and New Jersey. At all times material hereto the Fund maintained its principal offices at 2 World Trade Center, 19th Floor, New York, New York 10048-0649.

5. The Fund provides medical, dental and related health care services on an out-patient ambulatory basis to eligible employees and their dependents, and pensioners and their dependents, employed in the port of New York and New Jersey and covered under various collective bargaining agreements negotiated between the NYSA and the ILA, as well as under separate labor agreements between other employers and affiliated locals of the ILA. These benefits are provided through three medical centers owned and operated by the Fund. One is located in the State of New Jersey and two are located in the State of New York. The New York medical centers are located at 600 Avenue of the Americas, New York, New York 10011 and 340 Court Street, Brooklyn, New York 11231.

6. The Fund and its medical centers are an employee benefit plan within the meaning of ERISA §§ 2 (1), 2 (3) and 502 (d) (1), 29 U.S.C. §§ 1002 (1), 1002 (3) and 1132 (d) (1), and are a multiemployer plan within the meaning of ERISA §§ 2 (37) and 515, 29 U.S.C. §§ 1002 (37) and 1145.

7. Defendant David Axelrod, M.D. is the former and most recent New York State Commissioner of Health, and is named since that office is currently vacant. Defendant Lorna H. McBarnette is the New York State Executive Deputy Commissioner of Health. Defendant Steven C. Anderman is the Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health. Defendants David Axelrod, M.D., Lorna H. McBarnette and Steven C. Anderman were and are

charged with the overall general supervision, implementation and administration of New York Public Health Law § 2807-d.

NEW YORK PUBLIC HEALTH LAW § 2807-d

8. The beneficiaries of the Fund pay a $20-per-family annual registration fee and a $5-per-prescription charge. In addition the fund renders medical services to members of the Port Police and Guards Union, the waterfront security guards union, on a fee-for-services basis.

9. New York Public Health Law § 2807-d imposes an assessment on cash receipts of health facilities. Defendants have applied this statute to impose the assessment on plaintiffs.

10. In a letter dated April 19, 1991, plaintiffs advised defendants that they are of an employee benefit plan as defined in ERISA and that the assessment may not be levied on the plan, since the assessment is preempted by ERISA.

11. Plaintiffs have paid approximately $7,065 to defendants under protest.

12. In a letter, dated December 20, 1991 and received by plaintiffs January 2, 1992, defendants, through their counsel, advised plaintiffs that their position was that the assessment was not preempted by ERISA.

13. The Trustees of the Fund determined that to protect the assets of the Fund, no further payments would be made to defendants but that the monies would be placed in escrow pending resolution by the courts.

COUNT I

14. Plaintiff repeats paragraphs 1 through 13 as if fully set forth herein.

15. ERISA § 514 (a), 29 U.S.C. § 1144 (a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514 (c)(1), 29 U.S.C. § 1144 (c)(1), provides that "[t]he term 'State Law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."

16. New York Public Health Law § 2807-d relates to plaintiffs' plan.

17. New York Public Health Law § 2807-d contravenes Congress's intention to continue the exemption of employee benefit plans from state taxation.

18. For the foregoing reasons, New York Public Health Law § 2807-d is preempted by ERISA and therefore violates the Supremacy Clause of the Constitution of the United States.

WHEREFORE, plaintiffs request that judgment be entered:

1. Declaring New York State Public Health Law § 2807-d null, void and ineffective as applied to plaintiffs;

2. Permanently enjoining the defendants from administering and enforcing New York State Public Health Law § 2807-d insofar as it is applied to plaintiffs;

3. Awarding plaintiffs compensatory damages equal to the amounts paid to defendants; and

4. Interest, costs, disbursements, attorneys' fees and any other and further relief the Court deems just and proper.

Dated: New York, New York
April 16, 1992

THOMAS W. GLEASON

By: KEVIN MARRINAN
Kevin Marrinan (KM 6450)
26 Broadway, 17th Floor
New York, New York 10004
(212) 425-3240

LAMBOS & GIARDINO

By: RICHARD P. LERNER
C. Peter Lambos
Richard P. Lerner (RPL 1881)
29 Broadway, 9th Floor
New York, New York 10006
(212) 943-2470

Co-Counsel to Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

ANSWER

Defendants, by their attorney Robert Abrams, Attorney General of the State of New York, answer the complaint as follows:

FIRST: Neither admit nor deny the allegations contained in paragraphs "1", "2", "3", "15", "17" and "18" of the complaint as they constitute attempts to state conclusions of law to which no answer is required.

SECOND: Deny knowledge and information sufficient to form a belief as to the truth or falsity of the allegations contained in paragraph "4", "6", "8" and "13" of the complaint.

THIRD: Deny knowledge and information sufficient to form a belief as to the truth or falsity of the allegations contained in paragraph "5" of the complaint except admit that plaintiff NYSA-ILA Medical and Clinical Services Fund (the "Fund") provides health care services on an out-patient ambulatory basis through two medical centers which the fund operates in the State of New York and which have been issued operating certificates as diagnostic and treatment centers by the defendant New York State Department of Health pursuant to New York Public Health Law § 2805.

FOURTH: Admit the allegations contained paragraph "7" of the complaint, except allege that defendant Lorna H. McBarnette is currently the acting New York State Commissioner of Health.

FIFTH: Neither admit nor deny the allegations in paragraph "9" of the complaint as they constitute attempts to state conclusions of law to which no answer is required except admit that the requirement that an assessment be charged on the gross cash receipts of a hospital pursuant to New York Public Health Law § 2807-d applies to plaintiffs' medical centers since they are "hospitals" as defined in New York Public Health Law § 2801(1) and the assessment is charged irrespective of whether or not the "hospitals" are operated by a benefit fund qualified under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*.

SIXTH: Admit the allegations contained in paragraph "11" of the complaint except deny knowledge and information sufficient to form a belief as to the truth or falsity of the allegations that plaintiff's payment of approximately $7,065 to defendants was made "under protest" and, in further answer, allege that said payment was deposited in the general fund of the State of New York.

SEVENTH: Admit the allegations contained in paragraph "12" of the complaint except deny knowledge and information as to the date defendants reviewed a letter dated December 20, 1991 which was addressed to the attorneys of the Fund from Peter J. Millock, General Counsel to the New York State Department of Health.

EIGHTH: Deny the allegations contained in paragraph "16" of the complaint.

AS AND FOR A FIRST AFFIRMATIVE DEFENSE

NINTH: The complaint fails to state a claim upon which relief may be granted.

WHEREFORE, defendants respectfully request that the court dismiss the complaint in its entirety and grant all other relief which it deems just and proper.

Dated: June 8, 1992

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Defendants

By: RICHARD CORENTHAL
RICHARD CORENTHAL (RC 4009)
Assistant Attorney General
120 Broadway
New York, New York 10271
(212) 416-8711

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

STATEMENT OF UNDISPUTED MATERIAL FACTS PURSUANT TO LOCAL RULE 3(g)

Defendants, by and through their attorney, Robert Abrams, Attorney General of the State of New York, pursuant to Local Rule 3(g), submit this Statement of Undisputed Material Facts in support of a motion for summary judgment.

1. The plaintiff NYSA-ILA Medical and Clinical Services Fund ("the Fund") operates two medical centers in the State of New York which have been issued operating certificates as diagnostic and treatment centers by the defendant New York State Department of Health ("the Department") pursuant to New York Public Health Law § 2805.

2. As licensed diagnostic and treatment centers, the medical centers are "[h]ospitals", as defined in New York Public Health Law § 2801(1), and are charged an assessment on their gross cash receipts received from all patient care services and other operating income by the Department pursuant to New York Public Health Law § 2807-d.

3. The hospital assessment under New York Public Health Law § 2807-d applies to "[h]ospitals" as defined in New York Public Health Law § 2801(1) irrespective of whether or not such hospitals are operated by a benefit fund qualified under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*.

4. The Department has designated Blue Cross of Central New York, Inc. ("BCCNY") to act as the Department's administrative agent for collecting the assessments on hospitals' gross cash receipts authorized by New York Public Health Law § 2807-d. The Department has instructed "[h]ospitals", as defined in New York Public Health Law § 2801(1), including plaintiffs' two medical centers, to forward such hospital assessments on a monthly basis to BCCNY and BCCNY, in turn, forwards such monies to the general fund of the State of New York ("the State") pursuant to New York Public Health Law § 2807-d(9).

5. Defendants have paid $7,066.02 to the general fund of the State pursuant to New York Public Health Law § 2807-d(g).

Dated: New York, New York
June 8, 1992

Respectfully submitted,

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Defendants

By: RICHARD CORENTHAL
RICHARD CORENTHAL (RC 4009)
Assistant Attorney General
120 Broadway
New York, New York 10271
(212) 416-8711

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

AFFIDAVIT IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

RICHARD CORENTHAL, being duly sworn, deposes and says:

1. I am an Assistant Attorney General and Deputy Chief of the Labor Bureau on the staff of Robert Abrams Attorney General of the State of New York, attorney for the defendants herein.

2. This affidavit is submitted in support of the defendants' motion for summary judgment.

3. I have reviewed the "bill jacket" for Senate Bill 9190 maintained in the N.Y.S. Department of Law's Albany library. Exhibit A hereto. This bill, which was enacted as Chapter 938 to the Laws of 1989, and codified as N.Y. Public Health Law § 2807-d (PHL § 2807-d), authorizes an assessment on the monthly gross cash receipts of hospitals covered by Article 28 of the Public Health Law, including Article 28 diagnostic and treatment centers.

4. According to the report of the New York State Division of Budget submitted to the New York State Legislature in support of Senate Bill 9190, the bill's purpose was to generate revenue to help eliminate the deficit for the 1990-91 fiscal year and achieve savings in the State's Medicaid program.

5. The effective date of the assessment under PHL § 2807-d as originally enacted was January 1, 1991 and expired on April 1, 1992. A subsequent amendment to PHL § 2807-d enacted a "sunset" provision whereby the expiration date of PHL § 2807-d was extended to March 31, 1993. L. 1992, ch.41, § 162. Exhibit B hereto.

/s/ RICHARD CORENTHAL
RICHARD CORENTHAL (RC 4009)
Assistant Attorney General

Sworn to before me on
the 30th day of July, 1992

/s/ Jennifer S. Brand
Assistant Attorney General

CHAPTER 938

LAWS OF 1990 _____ MEMORANDUM NO. _____

SENATE BILL 9190 ASSEMBLY BILL _____

S. 9190 A. 12232

SENATE — ASSEMBLY

December 13, 1990

IN SENATE—Introduced by COMMITTEE ON RULES—read twice and ordered printed, and when printed to be committed to the Committee on Finance

IN ASSEMBLY—Introduced by COMMITTEE ON RULES—read once and referred to the Committee on Ways and Means

AN ACT to amend the public health law, the social services law and the mental hygiene law, in relation to assessing certain health care providers; and making an appropriation therefor: to amend the social services law, in relation to establishing the utilization control program; making an appropriation therefor: and to repeal certain provisions of the public health law; to create a temporary task force on hospital reimbursement and child health insurance issues and to amend chapter 266 of the laws of 1986, amending the civil practice law and rules relating to medical and dental malpractice; and repealing certain provisions of the public health law, the social services law and the mental hygiene law upon the expiration thereof.

DATE RECEIVED BY GOVERNOR:

12/14

ACTION MUST BE TAKEN BY:

12/26

DATE GOVERNOR'S ACTION TAKEN:

DEC. 21 1990

SENATE VOTE 47 Y 7 N HOME RULE MESSAGE __ Y ✔ N

DATE 12/13/90 BILL IS DISAPPROVED

ASSEMBLY VOTE 86 Y 52 N DATE _____

DATE 12/13/90 _____

COUNSEL TO THE GOVERNOR

NEW YORK STATE ASSEMBLY
TWO HUNDRED THIRTEENTH SESSION

REPRINT
DATE: 12/13/90

DATE: 12/13/1990
TIME: 11:59:59 PM

BILL: S9190 (A12232) R.R. NO: 1399 SPONSOR: RULES

Provides for assessments upon health care providers; appropriations; repealers

MESSAGE OF NECESSITY

Y	Abbate PJ	*NAY*	*Cochrane JC*
ABS	Abramson E	Y	Colman S
NAY	*Anderson RR*	Y	Connelly EA
NAY	*Balboni MA*	Y	Conners RJ
Y	Barbaro FJ	*NAY*	*Conte JD*
ABS	*Barnett HW*	*NAY*	*Cooke AT*
Y	*Barraga TF*	*NAY*	*Coombe RI*
NAY	*Becker GR*	Y	Crowley J
NAY	*Behan JL*	*NAY*	*D'Andrea RA*
Y	Bennett LE	Y	Daniels GL
Y	Bianchi IW	*NAY*	*Davidsen DR*
NAY	*Bonacic JJ*	Y	Davis G
Y	Boyland WF	Y	Dearie JC
Y	Bragman MJ	Y	Del Toro A
Y	Brennan JF	Y	Diaz HL
Y	Brodsky RL	Y	DiNapoli TP
NAY	*Brown HC*	Y	Dugan EC
NAY	*Bush WE*	*NAY*	*Eannace RJ*
NAY	Butler DJ	Y	Eve AO
Y	Canestrari RJ	Y	Farrell HD
NAY	*Casale AJ*	*NAY*	*Faso JJ*
Y	Catapano TF	Y	Feldman D
ABS	*Chesbro RT*	*NAY*	*Flanagan JJ*
Y	Clark RM	Y	Friedman G

NAY	*Frisa D*	Y	Marshall HM
NAY	*Gaffney RJ*	Y	Martinez I
Y	Gauti DF	Y	Mayersohn N
Y	Genovesi AJ	*ABS*	*McCann JW*
Y	Gottfried RN	*NAY*	*McGee PK*
Y	Graber VJ	*NAY*	*Miller RH*
Y	Grannis A	Y	Murphy MJ
Y	Green RL	Y	Murtaugh JB
Y	Greene A	Y	Nadler J
Y	Griffith K	*NAY*	*Nagle JF*
Y	Haremberg PE	Y	Nolan CT
ABS	*Harris GH*	EOR	Norman C
NAY	*Hasper J*	*NAY*	*Nortz HR*
NAY	*Hawley RS*	*NAY*	*Nozzolio MF*
NAY	*Healey PB*	*NAY*	*O'Neil JG*
Y	Heveal AG	*NAY*	*Ortloff C*
ABS	Hikind D	*NAY*	*O'Shea CJ*
Y	Hill KH	Y	Parment WL
Y	Hillman MC	*NAY*	*Parola FE*
Y	Hinchey MD	Y	Passanmante WF
NAY	*Holland JR*	*NAY*	*Pataki GE*
Y	Hoyt WB	Y	Phoffer AI
Y	Jacobs RS	Y	Pillittare JT
Y	Jenkins C	Y	Pordum FJ
Y	Kaufman SB	*NAY*	*Prescott DW*
Y	Keane RJ	*NAY*	*Proskin AW*
NAY	*Kelleher NW*	Y	Proud G
NAY	*King RL*	*NAY*	*Rappleyea CD*
Y	Koppell GO	*NAY*	*Reynolds TM*
Y	Lafayette IC	Y	Robach RJ
EOR	*Larkin WJ*	Y	Rosado D
Y	Lasher HL	*NAY*	*Saland SM*
NAY	*Leibell VL*	Y	Sandera S
Y	Lentol JR	*ABS*	*Sawicki J*
Y	Lopez VJ	Y	Schimminger RL
Y	Luster MA	NAY	Schmidt FD
NAY	*Madison GH*	Y	Seabrook L

NAY	*Sears WR*	Y	Tonko PD
Y	Seminerio AS	Y	Vann A
ABS	Siegel MA	Y	Vitalinno EN
Y	Silver S	*NAY*	*Warren GE*
NAY	*Singer CD*	Y	Weinstein HE
NAY	*Straniere RA*	Y	Weisenberg H
Y	Sullivan EC	Y	Weprin S
EOR	*Sullivan PM*	*NAY*	*Wertz RC*
Y	Sweeney RK	*NAY*	*Winner GH*
Y	Tallon JR	Y	Yevoli LJ
NAY	*Talomie FG*	Y	Young GP
NAY	*Tedisco J*	Y	Zaleski TM
Y	Tocci RC	Y	Zimmer MN
Y	Tokass P		Mr. Speaker

YEAS: 86 NAYS: 52

CONTROL: 25410634

CERTIFICATION: /s/ FRANCINE M. MISASI
CLERK OF THE ASSEMBLY

Legend: Y=YES, NAY=NO, NV=ABSTAIN, ABS=ABSENT,
ELB=EXCUSED FOR LEGISLATIVE BUSINESS,
EOR=EXCUSED FOR OTHER REASONS

SENATE

This Senate Bill — Senate No. 9190

by Sen. RULES — Assem. Rept. No. _____

Calendar No. 1959

Entitled: AN ACT to amend the public health law, the social services law and the mental hygiene law, in relation to assessing certain health care providers; and making an appropriation therefor; to amend the social services law, in relation to establishing the utilization control program; making an appropriation therefor; and to repeal certain provisions of the public health law; to create a temporary task force on hospital reimbursement and child health insurance issues and to amend chapter 266 of the laws of 1986, amending the civil practice law and rules relating to medical and dental malpractice; and repealing certain provisions of the public health law, the social services law and the mental hygiene law upon the expiration thereof

No. 1 [THREE DAY MESSAGE OF GOVERNOR]

The President put the question whether the Senate would agree to final passage of said bill, and the facts which necessitate an immediate vote thereon having been certified by the Governor, the same being upon the desks of the members in final form, it was decided in the affirmative, a majority of all the members elected voting in favor thereof and three-fifths being present as follows:

	Dist.		NAY	AYE
	17	*Mr. Babbush*		
	43	Mr. Bruno		
	25	*Mr. Connor*		
	40	Mr. Cook		
	61	Mr. Daly	EXCUSED	
	47			
	44	Mr. Farley		
	31	*Mr. Galiber*	_____	
	13	*Mr. Gold*		
	32	*Mr. Gonzalez*		
	37	Mrs. Goodhue	EXCUSED	
	26	Mr. Goodman		
	39	*Mr. Gray*		
	18	*Mr. Halperin*		
	6	Mr. Hannon		
	48	*Ms. Hoffmann*	_____	
	10			
	4	Mr. Johnson		
	53	Mr. Kehoe		
	33	*Mr. Korman*		
	52	Mr. Kuhl		
	2	Mr. Lack		
	1	Mr. LaValle		
	28	*Mr. Leichter*	_____	
	38			
	8	Mr. N. Levy		
	51	Mr. Libous		

	Dist.	(cont.)	NAY	AYE
	49	Mr. Lombardi		
	15	Mr. Maltese		
	24	Mr. Marchi		
	5	Mr. Manno		
	21	*Mr. Markowitz*		
	58	*Mr. Masiello*	—	
	46	Mr. McHugh		
	23	Mr. Mega		
	30	*Mrs. Mendez*		
	22	*Ms. Montgomery*	—	
	42	*Mr. Nolan*	—	
	27	*Mr. Ohrenstein*		
	14	*Mr. Onorato*		
	36	*Mrs. Oppenheimer*		
	11	Mr. Padavan		
	29	*Mr. Paterson*		
	54	*Mr. Perry*	EXCUSED	
	56	Mr. Present		
	55	*Mr. Quattrociocchi*		
	41	Mr. Rolison		
	50	Mr. Seward		
	60	Mr. Sheffer		
	9	Mr. Skelos		
	20	*Miss Smith*		
	19	*Mr. Solomon*	EXCUSED	
	35	Mr. Spano		
	57	*Mr. Stachowski*	—	

	Dist.	(cont.)	NAY	AYE
	45	Mr. Stafford		
	12	*Mr. Stavisky*		
	3	Mr. Trunzo		
	7	Mr. Tully		
	34	Mr. Velella		
	59	Mr. Volker		
	16	*Mr. Weinstein*		

AYES 47

NAYS 7

Ordered, that the Secretary deliver said bill to the Assembly and request its concurrence therein.

Session Year 1990

BUDGET REPORT ON BILLS

SENATE

No. S.9190

ASSEMBLY

No. A

Law: Public Health
Mental Hygiene
Social Services

The main provisions of this bill:

— assess hospitals and other health care providers six-tenths of one percent of their gross revenues through March 31, 1992, to help offset the costs of trend factor increases and other rate enhancements;

— provide supplementary bad debt and charity care rate adjustments through March 31, 1992, for hospitals with high percentages of Medicaid and indigent care discharges;

— make technical amendments to Chapters 922 and 923 of the Laws of 1990 governing reimbursement to hospitals for rate years 1991-1993;

— reduce Medicaid reimbursement for the 1991 inpatient rates to reflect the allowable statutory case-mix increase limits;

— reconfigure bad debt and charity care fund distributions as State Medicaid expenditures;

— authorize a program of Medicaid utilization controls for Home Relief recipients through March 31, 1992.

Other provisions of the bill conform income and resource Medicaid eligibility criteria to federal requirements; reduce adjustments to payment levels for prescription drugs from a

monthly to a biannual cycle; require submission of Medicaid claims within two years of date of service without exception; access $8 million in interest earned from the Bad Debt and Charity Care Pool funds, $1.7 million from the Professional Medicaid Conduct Special Revenue Account, and $10 million in surplus from the Medical Malpractice Excess Insurance funds as a one-time offset to State Medicaid costs; and authorize a loan of up to $62 million from the Bad Debt and Charity Care Pool funds to cover current year Medicaid liabilities.

Since enactment of this bill is necessary to eliminate the deficit for the 1990-91 fiscal year and achieve savings in the Medicaid program in 1991-91 and since a chapter amendment will be enacted to correct a technical flaw relating to the varied assessments for hospitals, we recommend approval of this bill.

12/18/90

/s/ [ILLEGIBLE]

[LETTERHEAD OF MEDICAL SOCIETY OF THE STATE OF NEW YORK]

December 20, 1990

Honorable Mario M. Cuomo
Governor of the State of New York
Executive Chamber
State Capitol
Albany, New York 12224

Dear Governor Cuomo:

We understand that you now have before you for consideration S.9190/A.12232, the recently negotiated deficit reduction proposal for the Medicaid program. Included in this proposal is authorization for the Commissioner of Social Services to implement a program of Medicaid Utilization Thresholds (MUTS). We urge that this provision of the legislation not be approved.

As you are well aware, utilization thresholds for Medicaid patients has been a highly controversial proposal for several years. While we appreciate that some of our concerns and recommendations for improvements to the program have been recognized and incorporated into its current form, we remain seriously concerned about MUTS' potential to be detrimental to quality of care, further erode physician relationship with the Medicaid program, and deter patients from seeking appropriate and much needed health care services. In brief, our opposition to MUTS can be summarized as follows:

- The program imposes an arbitrary maximum limit to health care for the poor;

- The program would create an incentive for shifting medical care from the less costly private setting to hospital emergency rooms;

- There is a potential for significant implementation problems in that the program does not encompass an appropriate recourse for the verification and authorization of medical care if the "system" encounters a functional problem (as it inevitably will, e.g., the computer network can malfunction, telephone lines can jam, staff determinations can backlog);

- The aforementioned functional problems would lead to an ethical dilemma regarding the treatment of patients whose eligibility for care cannot be verified;

- The addition of onerous eligibility and verification processes to an already abysmally low reimbursement schedule would discourage current and future providers and inhibit access to care; and

- Finally, the proposal is contradictory to New York State's public policy objectives of expanded access to quality health care for all New Yorkers. This program would arbitrarily segregate a segment of New York State's Medicaid population and limit services available to those persons. For this segment of the Medicaid population, this program represents nothing less than RATIONING OF MEDICAL AND HEALTH CARE SERVICES.

We, of course, recognize that New York State's fiscal condition warrants painful choices and that fiscally responsible policies are warranted to address the State's fiscal deficit. To this end, we would recommend that, in lieu of MUTS, the State could pursue other policy options. These recommendations include:

- Meaningful reform of the medical liability system. It is unconscienable to limit service to the poor when 20% of our health care dollar is being squandered on a

grossly inefficient system that does not appropriately meet the needs of any of the system's participants;

• Strengthen existing fraud and abuse activities with regard to providers but with complete and full protection of the due process rights of physicians;

• Strengthen the restricted service program for over-utilizing patients;

• Expand funding for alternate care programs, e.g. managed care; and

• Creation of a study commission to examine the total restructuring of the Medicaid program.

We cannot overstate our concern for the serious negative impact that this program would have on the Medicaid program and the harm it would cause to the quality and availability of medical services to poor New Yorkers. For the above-mentioned reasons, we respectfully request that you use your veto authority to disapprove this initiative.

Respectfully,

/s/ ROBERT A. MAYERS, M.D.
ROBERT A. MAYERS, M.D.
President

/s/ DONALD F. FOY
DONALD F. FOY
Executive Vice-President

/s/ GERARD L. CONWAY
GERARD L. CONWAY, ESQ.
Director

UNITED STATE DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—v.—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
COUNTY OF ALBANY)ss.:

RICHARD PELLEGRINI, being duly sworn, deposes and says:

1. I am Director of the Bureau of Financial Management and Information Support, New York State Department of Health ("Department") and, as such, I am familiar with the facts hereinafter set forth.

2. New York Public Health Law ("PHL") § 2807-d is a revenue raising measure that imposes a percentage assessment on hospital gross receipts. This assessment is imposed on all hospitals in New York with certain narrowly designed exceptions relating to financially distressed institutions. See PHL § 2807-d(1). "Hospitals" as defined in PHL 2807-d and in PHL Article 28 generally (see PHL § 2801(1)) encompass a variety of medical institutions, including diagnostic and treatment centers issued operating certificates pursuant to PHL § 2805. The two clinics operated by plaintiff in New York and referenced in the Complaint herein are PHL Article 28 licensed diagnostic and treatment centers and, as such, they come within the provisions of the gross receipts assessment provisions of PHL § 2807-d.

3. The Department has designated Blue Cross of Central New York, Inc. (BCCNY) to act as the Department's administrative agent for collecting these assessments. Hospitals have been instructed to forward such assessments on a monthly basis to BCCNY and BCCNY in turn forwards said monies to the State's general fund. These instructions are contained in a letter dated 1/24/91 which was sent by the Department to all affected health care facilities in New York. A copy of this letter of 1/24/91 is annexed hereto as Exhibit A.

4. The provisions of PHL 2807-d apply to plaintiffs' clinics solely because they are "hospitals" as defined in Article 28 of the Public Health Law and the provisions of PHL 2807-d apply to almost all hospitals. The status of these facilities as "hospitals" is in turn based on the nature of the medical services they provided. The fact that these clinics are

operated by an ERISA qualified union benefits fund is entirely irrelevant to their status as "hospitals" and to the fact that, as hospitals, they come within the ambit of PHL § 2807-d.

/s/ RICHARD PELLEGRINI
RICHARD PELLEGRINI

Sworn to before me this
11th day of June, 1992

/s/ ROBERT A. _____
Notary Public

ROBERT A. _____
Notary Public, State of New York
Qualified in Albany County
4667994
Commission Expires 5/31/94

[LETTERHEAD OF STATE OF NEW YORK
DEPARTMENT OF HEALTH]

January 24. 1991

RE: Health Facility Cash Receipt
Assessment Program

Dear Administrator/Comptroller:

The following will provide the necessary instructions for health care provider compliance with Chapter 938 of the Laws of 1990 which requires the payment of an assessment on cash operating receipts for the period January 1, 1991–March 31, 1992. This assessment was enacted by the New York State Legislature and signed into law by the Governor as an alternative to substantial Medicaid payment reductions which were considered necessary to resolve the State's current fiscal crisis

The providers listed below will be required to comply with these directives:

1. All Article 28 general hospitals, excluding those which have been designated as Financially Distressed Facilities pursuant to paragraph (c) of subdivision 19 of Section 2807-c of the Public Health Law, for cash operating receipts associated with all general hospital inpatient and ambulatory services, including services licensed under the Mental Hygiene Law, less any amounts received for personal needs allowances and refunds.

2. Article 28 Residential Health Care Facilities for cash operating receipts associated with all inpatient and adult day care services less any amounts received for personal needs allowances and refunds.

3. All Article 28 Diagnostic and Treatment Centers for cash receipts associated with health related and clinic services, excluding receipts from billed family planning units of service for facilities which possess a separate Medicaid Family Planning rate. For Diagnostic and Treatment Centers operated by a Health Maintenance Organization in accordance with Article 44 of the Public Health Law and Article 43 of the Insurance Law, cash receipts for services to HMO subscribers *shall not* be subject to the assessment.

4. All Article 36 Certified Home Health Agencies for cash operating receipts associated with all home care services.

5. All Article 36 Long Term Home Health Care Programs for cash operating receipts associated with all home care services, excluding waivered services identified as non-assessable in accompanying attachment regarding this program.

6. All Personal Care Service Providers, both licensed and exempt agencies, which possess a Title XIX (i.e., Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the Social Services Law, for cash operating receipts associated with the delivery of such service less receipts from Certified Home Health Agencies and Long Term Home Health Care Programs resulting from paraprofessional contract arrangements.

Attached are detailed instructions for each of the above referenced provider groups. These instructions should be followed carefully since they provide more explicitly directives on cash receipts which are affected by the assessment. Furthermore, for organizations which may fall in more than one of the provider groups referenced above, compliance with

instructions and resulting assessment payments *must be handled separately*.

Assessment payments for the applicable period are to be made on a *monthly basis*. Payments are due within *15 days* following each affected month. Consequently, providers are required to submit their first payment by *February 15, 1991* which will be calculated based on cash operating revenues received during the month of January 1991. Payments due for each subsequent month, through March 31, 1992, should be determined and submitted accordingly.

Monthly payment checks should be made to the payment of the *1991-92 Health Facility Assessment Fund* and mailed to:

Mr. Herbert Radeker
Assessment Fund Administrator
Blue Cross/Blue Shield of Central New York
344 South Warren Street
P.O. Box 4809
Syracuse, New York 13221

Each monthly payment should include an accounting summary indicating the actual basis for determining the facility's monthly assessment liability. As stated earlier, for organizations which fall in more than one of the above referenced provider groups *separate* payment checks and accounting summary's should be submitted for each applicable service category.

It should be noted that failure to comply with the directives outlined in this letter *will* result in the recoupment of your facility's estimated monthly assessment liability, along with interest and/or penalty, from various third party payments. Applicable statutory provisions (i.e., Section 2807-d(6)(8) and Section 3614-a(6)(8) of the Public Health Law; and Section 367-i(5)(7) of the Social Services Law) are summarized as follows:

1. If a monthly payment is not received within 15 days following the applicable assessment month, or if the

received payment is less than 70% of the State Commissioner of Health's estimate of the facility's monthly assessment liability, the unpaid balance increased by a 25% penalty will be recouped from the facility's Medicaid, Blue Cross and/or Health Maintenance Organization outstanding receipts.

2. If a monthly payment is determined to be less than 90% of the State Commissioner of Health's estimate of the facility's monthly assessment liability the balance due will be increased by a 12% interest charge which must be paid in the month proceeding notification of the balance due. If at least two previous monthly assessment payments within a six month period were determined to be less than 90% of such monthly estimates, the balance due increased by a 12% interest charge will be recouped from the facility's Medicaid, Blue Cross, and/or Health Maintenance Organization outstanding receipts.

The Commissioner of Health is required to provide a facility at least a three day notice of any estimated amount due along with the basis for calculating such amount, prior to its collection from the above stated third-party receipts. A facility may request a hearing to object to the estimates made by the Commissioner within 60 days of receipt of the notice on the amount due. The Commissioner is required to grant a hearing within 30 days of receipt of a facility's request for hearing or collection of the amount due.

Facilities will also be required to submit quarterly and *certified* annual reports on cash gross receipts for the affected months. The first report will be due on March 15, 1991 to reconcile cash gross receipts for January 1991. Thereafter, quarterly reports will be due within 45 days of the proceeding quarter to reconcile cash gross receipts for the previous quarter commencing with the January-March 1991 quarter. An annual *certified* cash gross receipts report will also be

required at the end of each affected annual period. Further instructions and required reporting forms will be supplied through a future transmittal.

Please read each applicable attached section carefully to determine the basis for establishing your facility's monthly assessment liability. Questions regarding this correspondence should be directed to the Bureau of Information Management and Analysis at (518) 474-1673.

Sincerely,

/s/ STEVEN C. ANDERMAN
Steven C. Anderman
Deputy Director
Division of Health Care Financing

ARTICLE 28 HOSPITAL
CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All hospitals licensed under Article 28 of the Public Health Law, excluding financially distressed hospitals as described in Paragraph (c) of Subdivision 19 Section 2807-c are assessed monthly a percentage of cash receipts from patient services and general operations.

Rate of Assessment

Facilities' assessment percentage, determined in accordance with the statute, is based upon the percentage of 1989 Medicaid inpatient revenues as a percentage of total 1989 inpatient revenues as reported on the 1989 Institutional Cost Report. The hospital rate of assessment schedule is as follows:

	Medicaid	0% to 10%	Assessment Rate	.5%
Hospital	"	10% to 15%	Assessment Rate	.525%
(Inpatient &	"	15% to 20%	Assessment Rate	.65%
Ambulatory	"	20%	Assessment Rate	.675%
services)				
Hospital-Based RHCF			Assessment Rate	.6%
Hospital-Based Certified Home Health Agencies			Assessment Rate	.6%
Hospital-Based Long Term Home Health Care Services			Assessment Rate	.6%
Hospital-Based Personal Care Services			Assessment Rate	.6%

If your Hospital does operate an RHCF, Certified Home Health Agency, Long Term Home Health Care Program, and/or Personal Care Service Program, you should also refer

to the applicable attachments regarding these programs and follow specified instructions accordingly.

Assessable Hospital Income

- ALL cash receipts from Patient Care Services less any amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991 through March 31, 1992.
- Investment Income, except as otherwise referenced on this attachment, received during January 1, 1991–March 31, 1992.
- Other Operating Income, including:

  Non-Patient Food Sales
  Laundry and Linen Services Revenue
  Social Work Services Revenue
  Housing Revenue
  Parking Revenue
  Housekeeping Services Revenue
  Telephone and Telegraph Revenue
  Data Processing Services Revenue
  Purchasing Services Revenue
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste
  Cash Receipts from Externally Granted Rebates and Refunds
  Vending Machine Commissions
  Other Commissions
  Television/Radio Rentals
  Non-patient Room Rentals
  Management Services Revenue
  Other Operating Revenue not specifically referenced below as being non-assessable.
  Transfers from Restricted Funds for Other Operating Expenses
  Gift Shop Revenue

If unable to separately identify *Other Operating Income* amounts due to commingled funds or inadequate records which are applicable to hospital versus hospital-based RHCF, Certified Home Health, Long Term Home Health and Personal Care Service assessable cash receipts, then the hospital inpatient assessment percent shall apply.

Non-Assessable Income

- Patient Personal Fund Allowances
- Investment Income from:

  Externally Restricted Plant Funds (e.g. sinking funds, operating escrow. funded depreciation).

  Medical Malpractice Insurance Funds
- Distributions from Bad Debt and Charity Care Regional Pools
- Primary Health Care Services Regional Pools
- Bad Debt and Charity Care for Financially Distressed Hospitals Statewide Pools and Bad Debt and Charity Care and Capital Statewide Pools created under Section 2807-c
- All schools leading to licensure
- Income from grants, charitable contributions, donations and bequests and governmental deficit financing.
- Donated Commodities
- Sales and Excise Taxes

Assessment Percentage

Please refer to the attached computation of your facility's assessment percentage. Changes or corrections to data should be submitted as specified on the attached.

RESIDENTIAL HEALTH CARE FACILITIES CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All residential health care facilities, which includes all nursing facilities previously certified as HRF's or SNF's licensed under Article 28 of the Public Health Law, are assessed six-tenths (.60%) of one percent on monthly cash receipts from resident and nonresident services and general operations.

Assessable Residential Health Care Facility Cash Receipts

- All cash receipts from patient care services less any amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991–March 31, 1992.
- Investment income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992.
- Cash receipts for the above period from patient services and other operating income, which will be assessed include:

Resident Service Revenue—All Sources
Nonresident Service Revenue—All Sources
Cash Receipts Applicable to Prior Periods
Supplies and Services Sold to Others
Private Duty Nursing Fees
Cafeteria, Gift Shop and Public Restaurants
Rental Income from Real Property, Equipment and Other Telephone and Telegraph Services
Television and Radio Rentals
Vending Machine Commissions and Other Commissions
Medical Records and Abstract Fees
Sale of Scrap and Waste
Barber and Beauty Shops

Cash Receipts for Externally Granted Rebates and Refunds
Transfers from Restricted Funds for Other Operating Expenses
Income from Unrestricted Bank Accounts
Income from Unrestricted Investments
Extraordinary Income
All Other Cash Receipts not specifically referenced below as being non-assessable:

Non-Assessable Cash Receipts

Grants
Charitable Contributions
Donations
Bequests
Income from Funded Depreciation Accounts
Income from Operating Escrow Account
Income from Mortgage Repayment Escrow Accounts
Patient Personal Fund Allowances
Income Earned on Patient Personal Funds
Government Deficit Financing
Sale and Excise Taxes

Payment Mechanism

Estimated payments shall be forwarded to the Commissioner or his designee on a monthly basis and are due on or before the fifteenth (15th) day following the end of a calendar month to which the assessment applies. Payments made by nursing facilities previously dually certified as SNFs and HRFs should be combined for the two previous certified entities.

ARTICLE 28 DIAGNOSTIC AND TREATMENT CENTER CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Diagnostic and Treatment Centers licensed under Article 28 of the Public Health Law are assessed a percentage on monthly cash receipts from patient services and general operations.

A facility's assessment percentage, determined in accordance with the statute, is based upon six-tenths of one percent of the facility's gross cash receipts received during the reporting period.

Assessable Diagnostic and Treatment Center Income

- All cash receipts from patient care services less amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991–March 31, 1992;
- Investment Income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992;
- Cash receipts from other operating income for the time period noted above which will be assessed include:

  Non-Patient Food Sales
  Social Work Services Revenue
  Housing Revenue
  Parking Revenue
  Housekeeping Services Revenue
  Gift Shop Revenue
  Revenues from Rental of Premises or Equipment
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste
  Cash Receipts from Externally Granted Rebates and Refunds
  Vending Machine Commissions
  Other Commissions

  Television/Radio Rentals
  Non-Patient Room Rentals
  Management Services Revenue
  Other Operating Revenue Not Specifically Referenced Below as Being Not Eligible For The Assessment
  Transfers from Restricted Funds for Other Operating Expenses

Non-Assessable Income

- Investment Income from Externally Restricted Plant Funds (Sinking Funds) and from funded depreciation.
- Distributions from Disproportionate Share Bad Debt/Charity Care Allowances to Primary Comprehensive Care Facilities
- Grants provided to County Sponsored Diagnostic and Treatment Centers as part of Local Public Health Aid financing
- Income received from grants, charitable contributions, donations, bequests, government deficit financing.
- Sales and Excise Taxes.

For Diagnostic and Treatment Centers operated by a health maintenance organization operating in accordance with Article 44 of the Public Health Law or Article 43 of the Insurance Law, receipts received for services to HMO subscribers *shall not* be subject to the assessment.

For those Diagnostic and Treatment Centers that have distinct Medicaid rates of payment for family planning services, the cash receipts from such services to Medicaid clients *shall not* be subject to the assessment.

CERTIFIED HOME HEALTH AGENCY
CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Certified Home Health Agencies certified under Article 36 of the Public Health Law are assessed a percentage on monthly cash receipts from patient services and general operations.

An agency's assessment percentage, determined in accordance with the statute, is based upon six-tenths of one percent of the agency's gross cash receipts.

Assessable Certified Home Health Agency Income

- All cash receipts from patient care services less amounts applicable to patient or third-party refunds, irrespective of payor source or service date, received during January 1, 1991–March 31, 1992;
- Investment Income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992;
- Cash receipts from other operating income for the time period noted above which will be assessed include:

  Social Work Services Revenue
  Patient Assessment and Case Management Revenue
  Parking Revenue
  Housing Revenue
  Housekeeping Service Revenue
  Gift Shop Revenue
  Non-Patient Food Sales
  Revenues from Rental of Premises or Equipment
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste
  Cash Receipts for Externally Granted Rebates and Refunds

  Vending Machine Commissions
  Other Commissions
  Other Operating Income Not Specifically Referenced Below as Being Not Eligible for the Assessment
  Transfers from Restricted Funds for Other Operating Expenses

Non-Assessable Income

- Investment Income from Externally Restricted Plant Funds (Sinking Funds) and from funded depreciation.
- Distributions from Disproportionate Share Bad Debt/Charity Care Allowances to Certified Home Health Agencies
- Income received from grants, charitable contributions, donations, bequests, and government deficit financing.
- Grants provided to Public Health Nursing Services as part of Local Public Health Aid financing.
- Sales and Excise Taxes.

For agencies that contract with a long term home health care program to provide patient care services to a LTHHCP patient, the cash receipts for such services *shall not* be subject to the assessment.

For those agencies that provide personal care services through contracts with a local Department of Social Services, please also refer to the Personal Care Service Providers Attachment.

LONG TERM HOME HEALTH CARE PROGRAM CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Long Term Home Health Care Programs certified under Article 36 of the Public Health Law are assessed a percentage on monthly cash receipts from patient services and general operations.

An agency's assessment percentage, determined in accordance with the statute, is based upon six-tenths of one percent of the agency's gross cash receipts.

Accessible Long Term Home Health Care Program Income

- All cash receipts from patient care services (excluding the waivered services listed in the "Non-Assessable Income" section below) less amounts applicable to patient or third-party refunds, irrespective of payment source or service date, received during January 1, 1991–March 31, 1992;
- Investment Income, except as otherwise referenced in this attachment, received during January 1, 1991–March 31, 1992;
- Cash receipts from other operating income for the time period noted above which will be assessed include:

  Social Work Services Revenue
  Patient Assessment and Case Management Revenue
  Parking Revenue
  Housing Revenue
  Housekeeping Service Revenue
  Gift Shop Revenue
  Revenues from Rental of Premises or Equipment
  Sale of Abstracts/Medical Records
  Sale of Scrap and Waste

  Cash Receipts from Externally Granted Rebates and Refunds
  Vending Machine Commissions
  Other Commissions
  Other Operating Income Not Specifically Referenced Below as Being Not Eligible for the Assessment
  Transfers from Restricted Funds for Other Operating Expenses

Non-Assessable Income

- Income from the following waivered services:

  Social Day Care
  Social Transportation
  Congregate Meals
  Home Maintenance Tasks
  Housing Improvement
  Moving Assistance
  Respite Care
  Personal Emergency Response System

- Investment Income from *Externally* Restricted Plant Funds (Sinking Funds) and funded depreciation.
- Income received from grants, charitable contributions, donations, bequests, and government deficit financing.
- Grants provided to Public Health Nursing Services as part of Local Public Health Aid financing.
- Sales and Excise Taxes.

For those agencies that provide personal care services through contracts with a local Department of Social Services, please also refer to the Personal Care Service Providers Attachment.

PERSONAL CARE SERVICE PROVIDERS CASH RECEIPTS ASSESSMENT INSTRUCTIONS

All Personal Care Service Providers, both licensed and exempt agencies, possessing a Title XIX (i.e., Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the Social Services Law will be required to pay to the State a .6% assessment on monthly cash receipts from January 1, 1991-March 31, 1992. The following will identify specific income sources which should be included and excluded from your agency's calculation of your monthly assessment liability.

Assessable Income

- All cash receipts from personal care services less amounts applicable to patient or third-party refunds, as defined by Section 367-i of the Social Services Law, irrespective of payment source or service date.
- All Investment and Rental Income earnings received by the corporate entity possessing the Personal Care Service contract with a Local Social Services District pursuant to Section 367-i of the Social Services Law.

Non-Assessable Income

- All cash receipts from patient care services, other than those defined above as personal care services, (e.g. nursing, therapies, home health aide, durable medical equipment, pharmaceuticals, etc.).
- All cash receipts from Certified Home Health Agencies and Long Term Home Health Care Programs received pursuant to paraprofessional contracts to supply personal care services to clients of such programs.

- Grants, charitable contributions, donations, bequests, and government deficit financing funds.
- Interest earned on capital funds which have been *externally* restricted for capital debt retirement purposes.
- Sales and Excise Taxes.

Payment Mechanism

Estimated payments, pursuant to the above, shall be forwarded to the Commissioner or his designee on a monthly basis and are due on or before the fifteenth (15th) day following the end of a calendar month to which the assessment applies.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

92 CIV. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

NOTICE OF MOTION

TO: ROBERT ABRAMS, Attorney General of the State of New York
JANE LAUER BAKER, Assistant Attorney General in Charge of Labor Bureau
RICHARD CORENTHAL, Assistant Attorney General
120 Broadway
New York, New York 10271
(212) 416-8711
Attorneys for Defendants

PLEASE TAKE NOTICE that in accordance with the briefing schedule established by the parties, plaintiffs will move this court pursuant to Fed. R. Civ. P. 56 for summary judgment

(A) adjudging that New York Public Health Law § 2807-d is null, void, and ineffective under the Supremacy Clause of Article VI of the Constitution of the United States because that state law is preempted by the Employee Retirement Income Security Act ("ERISA") to the extent that it assesses contributions or other payments for benefits provided by ERISA plans;

(B) enjoining defendants from administering and enforcing New York Public Health Law § 2807-d insofar as it requires plaintiffs to pay any assessments on contributions or other payments received by medical centers operated by them to provide healthcare benefits to ERISA plan beneficiaries; and

(C) granting restitution to plaintiffs in the amount of all preempted assessments previously paid together with lawful interest thereon.

This motion is based on the annexed Revised Rule 3(g) Statement, the annexed affidavit of Rubin D. Fier sworn to September 22, 1992, and exhibits thereto, the accompanying memorandum of law, and the pleadings and other proceedings heretofore had herein.

Dated: New York, New York
September 23, 1992

LAMBOS & GIARDINO

By: FRANCIS S. L'ABBATE
C. PETER LAMBOS (CL 0932)
FRANCIS S. L'ABBATE (FL 8545)
29 Broadway - 9th Floor
New York, New York 100006
(212) 943-2470

LAW OFFICE OF
THOMAS W. GLEASON

By: KEVIN MARRINAN
KEVIN MARRINAN (KM- 6450)
26 Broadway - 17th Floor
New York, New York 10004
(212) 425-3240

Co-Counsel to Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

REVISED STATEMENT OF UNDISPUTED MATERIAL FACTS

Plaintiffs, by and through their attorneys, Thomas W. Gleason and Lambos & Giardino, pursuant to Local Rule 3(g), submit this revised statement of undisputed material facts in support of a motion for summary judgment.

1. The NYSA-ILA Medical and Clinical Services Fund ("the Fund") provides medical, dental, and other healthcare services on an out-patient ambulatory basis to eligible employees, pensioners, and their dependents through three medical centers owned and operated by the Fund, two of which are located in the State of New York.

2. The Fund and its medical centers are a multiemployer employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act.

3. New York Public Health Law § 2807-d imposes an assessment on the cash receipts of the two New York medical centers operated by the Fund.

4. The cash receipts upon which the assessment is imposed consist of the following contributions or other payments for healthcare benefits provided to ERISA plan beneficiaries:

a) Man-hour contributions paid by non-longshore employers as required by their collective bargaining agreements;

b) Payments from the NYSA-PPGU Welfare Fund for medical and dental services rendered to its beneficiaries;

c) Worker compensation insurance payments for healthcare services provided to Fund beneficiaries;

d) Prescription charges paid by Fund beneficiaries; and

e) Annual registration fees paid by Fund beneficiaries.

5. Plaintiffs have paid $7,066.02 to defendants under protest, of which $6,953.47 represents assessments imposed on contributions or other payments for healthcare benefits provided to ERISA plan beneficiaries.

Dated: New York, New York
September 23, 1992

LAMBOS & GIARDINO

By: FRANCIS S. L'ABBATE
C. Peter Lambos (CL 0932)
Francis S. L'Abbate (FL 8545)
29 Broadway - 9th Floor
New York, New York 100006
(212) 943-2470

LAW OFFICE OF
THOMAS W. GLEASON

By: KEVIN MARRINAN
Kevin Marrinan (KM 6450)
26 Broadway - 17th Floor
New York, New York 10004
(212) 425-3240

Co-Counsel to Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiffs,

—against—

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

RUBIN D. FIER, being duly sworn, deposes and says:

1. I am the treasurer of the NYSA-ILA Medical and Clinical Services Fund (hereinafter "Fund"), which along with its trustees are the plaintiffs in this lawsuit. I make this affidavit in support of plaintiffs' motion for summary judgment invalidating on Employee Retirement Income Security Act (hereinafter "ERISA") preemption grounds the imposition by the State of New York of an assessment on certain contributions received by medical centers operated by the Fund to provide healthcare benefits to the Fund's participants and their dependents. I am intimately acquainted with the affairs of the Fund and its medical centers and have personal knowledge of the facts set forth in this affidavit.

Structure of the Fund

2. The Fund is a jointly administered, multiemployer, labor-management trust fund established in accordance with § 302(c)(5) of the Labor Management Relations Act, 29 U.S.C.A. § 186(c)(5) (West Supp. 1992), and pursuant to an Agreement and Declaration of Trust and Plan and collective bargaining agreements between the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA"), prescribing the terms and conditions of longshore employment in the Port of New York and New Jersey. The Fund is a self-insured employee welfare benefit plan under ERISA § 3(1), 29 U.S.C.A. § 1002(1) (West Supp. 1992), that provides medical, dental and related healthcare services on an out-patient ambulatory basis to over 20,000 eligible beneficiaries consisting of plan participants and their dependents, including more than 13,000 in the State of New York.

3. There are four classes of persons receiving healthcare services from the Fund. The first and predominant class consists of longshore workers and retirees and their dependents, whose right to Fund benefits stems from longshore employment in the Port. The NYSA-ILA labor contract entitles these

individuals to receive healthcare at medical centers operated by the Fund in the states of New York and New Jersey. The second class is composed of warehouse and other workers represented by non-longshore ILA locals who are eligible for treatment at Fund medical centers under the terms of separate labor contracts with their employers, who for purposes of differentiating them from longshore employers are classified by the Fund as "outside employers." Private police responsible for cargo security at waterfront terminals in the Port comprise the third class of persons receiving healthcare services provided by the Fund. These waterfront security personnel are represented by the Port Police and Guards Union ("PPGU"). The fourth and final group of beneficiaries consists of local union officers and employees who are eligible to use the Fund's medical centers by virtue of their locals' agreements with the Fund.

4. The Fund provides healthcare benefits through medical centers that it owns and operates. Prior to 1992 the Fund operated four medical centers: two in New York and two in New Jersey. Only the two medical centers in New York—the Brooklyn center and the Manhattan center—are subject to the assessment challenged in this case. The Fund's medical centers are not open to the general public but are available only to those eligible to receive healthcare services from the Fund.

5. The Fund and its centers operate exclusively for nonprofit purposes and conduct no trade, business, or commercial activity of any kind. They are not subject to federal, state, or local income taxation. They are also exempt from the New York City General Corporation and Unincorporated Business Taxes, the New York City Commercial Rent or Occupancy Tax, and the New York City Real Property Tax.

6. The Fund is exempt from taxation pursuant to Section 501(c)(9) of the Internal Revenue Code as a voluntary employees' beneficiary association. Copies of the August 12, 1963, exemption letter and the July 18, 1979, letter advising

that the exemption letter continues in effect are attached to my affidavit as Exhibit 1.

7. The 501(c)(9) tax exempt status extends to both the Fund and its medical centers. The Fund's Return of Organization Exempt From Income Tax (IRS Form 990) includes the operations of both the Fund and the medical centers. A sample copy of this tax return for calendar year 1991 is attached to my affidavit as Exhibit 2.

8. The Fund also reports to the Internal Revenue Service and the United States Department of Labor, Pension and Welfare Benefits Administration, on Form 5500, since the Fund is covered by ERISA. The Fund's 5500 report includes the operations of both the Fund and its medical centers. A sample Form 5500 filed by the Fund for calendar year 1990 is attached to my affidavit as Exhibit 3.

Financing of the Fund

9. Employer contributions are the principal source of monies used to fund the healthcare benefits provided by the Fund. Some employer contributions are made to the Fund directly and are then funnelled to the centers. Other employer contributions are paid directly to the medical centers. Employers of longshore workers are obligated by the NYSA-ILA collective bargaining agreement to pay assessments that fund fringe benefits through an assessment imposed on cargo and containers transported through the Port. These assessments fund all employee fringe benefits for longshore workers, including pension benefits, welfare benefits, medical and clinical benefits, etc. The portion of the assessments that fund medical and clinical benefits is paid to the Fund on a weekly basis. The Fund then funnels an amount sufficient to meet the weekly expenses for each of the medical centers. The weekly amount transferred to the centers is based upon prior experience and is adjusted periodically to conform to current fiscal demands. Should the Fund transfer more than is needed

for a particular week, a lesser amount would be forwarded to the medical centers in later weeks.

10. A second source of employer contributions comes from various ILA local unions which pay to the Fund directly man-hour contributions on behalf of their officers and employees. These contributions in turn form part of the monies transferred weekly to the medical centers on an as-need basis.

11. Outside employers pay man-hour contributions for the medical and clinical benefits provided to their employees as required by the terms of their separate labor agreements. Since many of these outside employers operate single facilities, their employees are eligible to be treated only at the medical center nearest their workplace. Consequently, each outside employer has historically paid its contributions directly to the medical center at which its employees are eligible to be treated. Although the outside employers' contributions could be paid to the Fund itself, direct payment to the medical center simplifies what would otherwise be a cumbersome internal administrative problem of allocating these outside contributions to the appropriate medical centers.

12. Waterfront security guards in the Port are participants in their own ERISA welfare plan, the NYSA-PPGU Welfare Fund, which provides medical and clinical benefits for the guards and their dependents. Excessive costs forced the NYSA-PPGU Welfare Fund to close its own medical center in July 1988. At a later date it entered into a contractual arrangement with the Fund to allow port guards and their dependents to be treated at the medical centers operated by the Fund. The NYSA-PPGU Welfare Fund pays for medical and dental services rendered to its participants on a fee-for-service basis.

13. The final source of contributions, made only to the Brooklyn Medical Center, consists of receipts from workers' compensation insurance carriers. The Brooklyn Medical Center is authorized by N.Y. WORK. COMP. LAW § 13-c (3) (McKinney 1992) to service Fund participants who have been

injured on the job and are covered by workers' compensation insurance. The Brooklyn Medical Center bills the insurance carrier for the medical services it renders to participants, all of whom are eligible for treatment at the center. The workers' compensation payments received by the Brooklyn Center offset the costs of healthcare services which the Fund must provide and which would have had to be financed by contributions from the same employers paying for the workers' compensation coverage.

14. In light of the dramatic cost increases experienced in recent years, the Fund had to change its traditional method of being funded solely by employer contributions. The NYSA-ILA labor contract for the three year period from October 1, 1986, to September 30, 1989, inaugurated a new method of employee contributions. To help defray rising costs, the NYSA-ILA labor agreement imposed a prescription charge of $2.00 per prescription on each beneficiary to whom prescription drugs are dispensed at any medical center. This was the first time that any obligation for medical costs was placed directly upon the beneficiaries of the Fund. It produced revenue of approximately $1 million per annum.

15. Costs continued to escalate at an alarming rate. As a result, the 1990-1994 longshore labor contract imposed additional obligations on Fund participants. A $20 per-family, annual registration fee was inaugurated, and the prescription charge was increased to $5.00. Even these additional employee contributions were insufficient to meet the skyrocketing costs experienced by the Fund. Consequently, the Fund was forced to close one of its four medical centers. This defunct center was located in Hoboken, New Jersey.

Health Facility Assessment

16. Effective January 1, 1991, the State of New York enacted a Health Facility Assessment on the gross receipts from patient care services of general hospitals, residential healthcare facilities, and diagnostic and treatment centers.

The Fund's medical centers fell within the third category of facilities subject to the assessment. The assessment on the Fund's medical centers is now fixed at "six-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis." N.Y. PUB. HEALTH LAW § 2807-d(2)(c) (McKinney Supp. 1992).

17. On January 24, 1991, the New York State Department of Health issued a letter to all hospitals and facilities subject to the assessment. A copy of this letter, which contained separately attached instructions for reporting and paying the assessment, is attached as Exhibit "A" to the June 11, 1992, affidavit of Richard Pellegrini, which was submitted by defendants in support of their motion for summary judgment. The instructions for Article 28 Diagnostic and Treatment Centers lists both assessable receipts and non-assessable receipts. The former includes cash receipts from patient care services, investment income, and cash receipts from certain enumerated categories of operating income, including sale of abstracts/medical records, sale of scrap and waste, and commissions. The latter includes "Income received from grants, charitable contributions, donations, bequests, government deficit financing."

18. The first health facility assessment reports submitted by the Fund on behalf of the Brooklyn and Manhattan medical centers covered the nine-month period ending September 30, 1991. Copies of these initial reports and the succeeding monthly reports for October and November 1991 are attached to this affidavit as Exhibit 4. Upon advice of co-counsel the Fund concluded that neither the statute nor the instructions imposed any assessment on monies transferred weekly by the Fund to the medical centers to meet their operating expenses. None of these transfers related to the furnishing of services for particular patient care or constituted income from the operations of the centers. These transfers were no more than the utilization of employer contributions to provide the

healthcare benefits furnished by the Fund through its medical centers. These weekly transfers of employer contributions are akin to grants and other types of non-assessable receipts. I did include on Item 1 of the report, which is entitled "Cash From Patient Care Services," the following revenue items received directly by the medical centers:

Outside Employer Contributions
NYSA-PPGU Welfare Fund Payments
Prescription Charges From Beneficiaries
Registration Fees From Participants
Payments From Workers' Compensation Carriers
Fees For Medical Examinations of Applicants For Disability Pensions

Under Item 5 of the report, which is entitled "Other Assessable Cash Receipts," both centers listed various miscellaneous items, including interest on the refund of payroll taxes, fees for reproducing medical records, and proceeds from the sale of scrap and waste.

19. For the period commencing on January 1, 1991, and ending on November 30, 1991, the Fund reported and paid assessments on the following:

Reported Item	Brooklyn Center	Manhattan Center	Total
Item 1			
Outside Employer Contributions	$199,573	—	$199,573
Prescription Charges	407,180	195,765	602,945
Registration Fees	112,640	55,364	168,004
Workers' Compensation Payments	51,255	—	51,255
NYSA-PPGU Welfare Fund Payments	78,456	56,878	135,334
Disability Pension Examinations	1,800	—	1,800

Reported Item	Brooklyn Center	Manhattan Center	Total
Item 5			
Medical Abstracts/Records	13,961	1,739	15,700
Sale of Scraps/Waste	227	21	248
Telephone Commissions	216	—	216
Supplier Rebates	1,119	—	1,119
Interest on Payroll Taxes	610	866	1,476
	$867,037	$310,633	$1,177,670

The total Health Facility Assessments paid by the Fund amounted to $7,066.02, consisting of $5,202.22 for the Brooklyn center and $1,863.80 for the Manhattan center.

20. On April 19, 1991, the Fund submitted a protest to the Department of Health of the State of New York challenging the imposition of the Health Facility Assessment on medical centers operated by an ERISA welfare plan. The protest, a copy of which is annexed to this affidavit as Exhibit 5, urges discontinuance of the assessment against the Fund and its medical centers because the assessment is preempted by ERISA. No response to the protest was forthcoming until December 20, 1991. In the interim, in order to avoid interest and penalties, the Fund filed the assessment reports attached hereto as Exhibit 4 for the eleven-month period ending November 30, 1991, and paid the applicable assessments for that period. By letter dated December 20, 1991, a copy of which is attached to this affidavit as Exhibit 6, the New York State Department of Health rejected the Fund's protest. The Fund then ceased payment of the assessment and commenced this action. The Fund discontinued the filing of assessment reports and began placing the amount of assessments that would have been paid in a separate escrow account.

21. The Fund has also restructured its payment procedures. Since early 1992 the registration fees and the payments from the NYSA-PPGU Welfare Fund are remitted to the Fund, not

to the medical centers. Although the Fund can redirect to the Fund all payments now received by the medical centers and thus effectively circumvent the Health Facilities Assessment, it has not done so pending the outcome of this litigation.

/s/ RUBIN D. FIER
RUBIN D. FIER

Sworn to before me this
22nd day of September, 1992

/s/ RAY TARONE
Notary Public

RAY TARONE
Notary Public, State of New York
No. 31-9484625
Qualified in New York County
Commission Expires Feb. 28, 1993

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR January 1, 1991 to Sept. 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF BROOKLYN, INC.

OPERATING CERTIFICATE NO. 7001205R

WHOLE DOLLARS ONLY

A	B	C	D	E
ASSESSABLE PROVIDER INCOME	CURRENT MONTH	PRIOR PERIOD ADJUSTMENT	ADJUSTED AMOUNT	YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 714,099	$ —	$ 714,099	$ 714,099
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 714,099	$	$ 714,099	$ 714,099
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	11,422		11,422	11,422
Sale of scrap & waste	177		177	177
NY telephone commissions	198		198	198
Interest—tax refunds	607		607	607
Rebates	1,119		1,119	1,119
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 13,523	$	$ 13,523	$ 13,523
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 727,622	$	$ 727,622	$ 727,622
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$4,365.73	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$4,365.73	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$	
13. TOTAL PAYMENTS YEAR-TO-DATE				$

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAY-MENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED October 31, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF BROOKLYN, INC.

OPERATING CERTIFICATE NO. 7001205R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 60,816	$	$ 60,816	$ 774,915
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 60,816	$	$ 60,816	$ 774,915
4. CASH RECEIVED FROM INVEST-MENTS	$ —	$	$	$ —
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	1,230		1,230	12,652
Sale of scrap & waste	—		—	177
NY telephone commissions	—		—	198
Interest—tax refunds	3		3	610
Rebates	—		—	1,119
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 1,233	$	$ 1,233	$ 14,756
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 62,049	$ —	$ 62,049	$ 789,671
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 372.24	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$ 372.24	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$ 4,738.02

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAYMENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED November 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF BROOKLYN, INC.

OPERATING CERTIFICATE NO. 7001205R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 75,989	$	$ 75,989	$ 850,904
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 75,989	$	$ 75,989	$ 850,904
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	1,309		1,309	13,961
Sale of scrap & waste	50		50	227
NY telephone commissions	18		18	216
Interest—tax refunds	—		—	610
Rebates	—		—	1,119
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 1,377	$	$ 1,377	$ 16,133
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 77,366	$	$ 77,366	$ 867,037
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 464.20	
10. OTHER ADJUSTMENTS			$	
11. AMOUNT DUE			$ 464.20	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$ 5,202.22

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAYMENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NYSA-ILA MEDICAL CENTER OF NEW YORK

Detail of Line 1

Cash From Patient Care Services

	1-1-91 to 9-30-91	Oct. 1991	Nov. 1991	1-1-91 to 11-30-91
Pharmacy surcharge	154,732	17,520	23,513	195,765
Registration fee	54,640	304	420	55,364
PPGU recoveries	48,077	5,645	3,156	56,878
	257,449	23,469	27,089	308,007

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR January 1, 1991 to Sept. 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF NEW YORK

OPERATING CERTIFICATE NO. 7002221R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 257,449	$	$ 257,449	$ 257,449
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 257,449	$	$ 257,449	$ 257,449
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	1,135		1,135	1,135
Sale of scrap and waste	21		21	21
Interest—tax refunds	866		866	866
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 2,022	$	$ 2,022	$ 2,022
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 259,471	$	$ 259,471	$ 259,471
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$1,556.83	
10. OTHER ADJUSTMENTS			$	
11. AMOUNT DUE			$1,556.83	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAY-MENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED October 31, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF NEW YORK

OPERATING CERTIFICATE NO. 7002221R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 23,469	$ —	$ 23,469	$ 280,918
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 23,469	$ —	$ 23,469	$ 280,918
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESSABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	223		223	1,358
Sale of scrap and waste	—		—	21
Interest—tax refunds	—		—	866
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 223	$	$ 223	$ 2,245
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 23,692	$	$ 23,692	$ 283,163
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 142.15	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$ 142.15	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$	
13. TOTAL PAYMENTS YEAR-TO-DATE				$ 1,698.98

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAY-MENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

HEALTH FACILITY CASH RECEIPT ASSESSMENT REPORT
FOR THE MONTH ENDED November 30, 1991

PROVIDER NAME NYSA-ILA MEDICAL CENTER OF NEW YORK

OPERATING CERTIFICATE NO. 7002221R

WHOLE DOLLARS ONLY

A ASSESSABLE PROVIDER INCOME	B CURRENT MONTH	C PRIOR PERIOD ADJUSTMENT	D ADJUSTED AMOUNT	E YEAR-TO-DATE AMOUNT
1. CASH FROM PATIENT CARE SERVICES	$ 27,089	$ —	$ 27,089	$ 308,007
2. LESS PATIENT OR THIRD PARTY REFUNDS				
3. NET CASH FROM PATIENT CARE SERVICES	$ 27,089	$ —	$ 27,089	$ 308,007
4. CASH RECEIVED FROM INVEST-MENTS	$	$	$	$
5. OTHER ASSESS ABLE CASH RECEIPTS (LIST)				
Medical records—subpoenas	381	—	381	1,739
Sale of scrap and waste	—		—	21
Interest—tax refunds	—		—	866
6. SUBTOTAL OTHER ASSESSABLE CASH RECEIPTS	$ 381		$ 381	$ 2,626
7. TOTAL ASSESS-ABLE RECEIPTS (LINE 3+4+6)	$ 27,470	$	$ 27,470	$ 310,633
8. ASSESSMENT RATE			.006	
9. CURRENT MONTH ASSESSMENT			$ 104.83	
10. OTHER ADJUSTMENTS			$ —	
11. AMOUNT DUE			$ 104.83	
12. EXCESS CREDIT FOR FUTURE REMITTANCE			$ —	
13. TOTAL PAYMENTS YEAR-TO-DATE				$[ILLEGIBLE]

MONTHLY PAYMENT CHECKS SHOULD BE MADE TO THE PAYMENT OF THE 1991-92 HEALTH FACILITY ASSESSMENT FUND AND MAILED TO: MR. HERBERT RADEKER

[LETTERHEAD OF NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND]

April 19, 1991

VIA FEDERAL EXPRESS

Steven C. Anderman,
Deputy Director
Division of Health Care Financing
State of New York
Department of Health
Corning Tower
The Governor Nelson A. Rockefeller
Empire State Plaza
Albany, New York 12237

Dear Mr. Anderman:

The undersigned are Co-Counsel to the NYSA-ILA Medical Center of Brooklyn, Inc. and the NYSA-ILA Medical Center of New York, Inc. ("the Medical Centers"), both of which are in receipt of your recent letter concerning the Health Facility Cash Receipt Assessment Program ("the Assessment"). The undersigned are also Co-Counsel to the NYSA-ILA Medical and Clinical Services Fund ("the Fund") which owns both Medical Centers.

This statement is submitted in support of the Medical Centers' position that they are not subject to the Assessment since they are not-for-profit tax exempt organizations and integral parts of an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"). Accordingly, the Assessment may not be levied on the plan since it is pre-empted by ERISA.

Background

The Medical Centers are not-for-profit corporations incorporated by special acts of the New York Legislature (Chapter 988, Laws of New York 1957, as amended by Chapter 818, Laws of New York 1958, Chapter 807, Laws of New York 1961 and Chapter 1013, Laws of New York 1974; Chapter 624, Laws of New York 1958, as amended by Chapter 758, Laws of New York 1961 and Chapter 594, Laws of New York 1963). The Medical Centers render out-patient, ambulatory medical, dental and related health care services to approximately 17,000 longshore workers employed in the Port of New York and New Jersey and their dependents and pensioners and their dependents. The Medical Centers do not operate independently of the Fund. The Fund owns the Medical Centers and the land on which they are located. More importantly, the Fund provides the monies necessary for their operation. (The Fund also owns and provides the monies necessary for the operation of the NYSA-ILA Medical Centers of Newark and Hoboken which treat approximately 13,000 longshore workers, pensioners and dependents.)

The Fund is a joint labor-management trust fund established pursuant to a collective bargaining agreement between the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association, AFL-CIO ("ILA"). A copy of the Memorandum of Settlement of the Port of Greater New York and New Jersey dated November 28, 1990 and effective December 1, 1990 through September 30, 1994 is submitted herewith as Exhibit 1. Provisions relating to the Fund and Medical Centers are on pages 3-5 and page 8.

The Fund is a Taft-Hartley Trust Fund under Section 302 of the Labor-Management Relations Act of 1949, 29 U.S.C. §186. It is also exempt from taxation pursuant to Section 501(c)(9) of the Internal Revenue Code as a voluntary employees' beneficiary association. Copies of the August 12, 1963 exemption letter and the July 18, 1979 letter advising that the exemption letter continues in effect are submitted

herewith as Exhibit 2. As noted previously the Fund is an employee welfare benefit plan as defined in ERISA. ERISA § 3(1), 29 U.S.C. § 1002(1).

The 501(c)(9) tax exempt status of the Fund encompasses the Medical Centers. The Fund's Return of Organization Exempt From Income Tax (Form 990) includes the operations of the Fund and the Medical Centers. A copy of the Fund's Form 990 for 1989 is submitted herewith as Exhibit 3.

As an ERISA Fund the Fund also reports to the Internal Revenue Service and Department of Labor on Form 5500, which also includes the operations of the Fund and the Medical Centers. A copy of the Fund's 1989 Form 5500 is submitted herewith as Exhibit 4.

As noted above, the Fund, through the Medical Centers, provides medical, dental and related health care services on an out-patient ambulatory basis to approximately 12,500 participants and their dependents eligible under the NYSA-ILA collective bargaining agreement. The beneficiaries do not pay for services rendered to them, except for a $20-per-family annual registration fee and a $5-per-prescription charge.*

The Fund and Medical Centers all operate exclusively for nonprofit purposes and conduct no trade, business or commercial activity of any kind.** They are not subject to federal, state or local income taxation. The Medical Centers are exempt from the New York City General Corporation and Unincorporated Business Taxes, the New York City Commercial Rent or Occupancy Tax, and the New York City Real Property Tax. Copies of the Medical Centers' December 3, 1990 Requests For Continuation of Real Property Tax Exemp-

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* The Medical Centers provide medical and dental services to eligible participants under the NYSA-PPGU Welfare Fund. That fund's participants are the waterfront security guards and their dependents. The NYSA-PPGU Welfare Fund pays for these services on a fee-for-service basis in accordance with a contract between the NYSA-PPGU Welfare Fund and the Fund on behalf of the Medical Centers.

** The Fund's Form 990 for 1989 (Exhibit 3) shows a negative fund balance of over 4 million dollars both at the beginning and end of the year.

tions, and the January 15, 1991 letters continuing the real property tax exemption as to three of the five lots owned by the Fund are submitted herewith as Exhibit 5. Official notification letters have not yet been received as to the other two lots although the Fund does not pay real property taxes on them.

The Medical Centers Are Not Subject To The Assessment Since They Are Tax Exempt, Integral Parts of An ERISA Employee Welfare Benefit Plan. Thus, The Assessment Is Pre-Empted By ERISA

Section 514 of ERISA, 29 U.S.C. § 1144, provides:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the

extent it provides for more than the effective administration of such Act as in effect on such date.

* * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

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Thus, state laws which relate to employee welfare benefit plans, including state tax laws, are expressly pre-empted by ERISA.

See Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41 (1987) (noting the "expansive sweep" of the pre-emption clause); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) (Congress used the words "related to" in § 514(a) in their broad sense); *Birdsong v. Olson*, 708 F.Supp. 792 (W.D. Texas 1989) ("Congress has expressly indicated that state tax laws related to employee welfare benefit plans are preempted"); *Northwest Airlines, Inc., et al. v. Roemer, et al.*, 603 F.Supp. 7 (D. Minnesota 1984) ("In 1983, when ERISA's preemption language was amended to exclude Hawaii's experimental health benefit statute from § 1144(a), Congress specifically endorsed the preemption of state tax laws."); *National Carriers' Conference Committee, et al. v. Heffernan*, 454 F.Supp. 914 (D. Connecticut 1978) (because of the potential use of

taxation as a means of regulation, preempting state taxation of ERISA-covered plans is necessary to effectuate Congressional objectives).

Accordingly, to apply the Assessment to the Medical Centers would be in violation of the pre-emption provisions of ERISA and the cases decided thereunder.

Conclusion

The State of New York is pre-empted by ERISA from applying the Assessment to the NYSA-ILA Medical Center of Brooklyn, Inc. and the NYSA-ILA Medical Center of New York, Inc.

If you require any further information, please contact the undersigned.

Very truly yours,

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cc: Board of Trustees
NYSA-ILA Medical and Clinical Services Fund

Board of Directors
NYSA-ILA Medical Centers of New York and Brooklyn, Inc.